| Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0032 | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | 01/20/2011 | | |
| | OMEN'S AND CHIL | | SO1 PENN | | STATE, ZP CODE AVENUE, NW, SOUTH BLOG SUITE 1904 | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FOLL | | | id Prefix Tag | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | NED SE COMPLETE |
| An annual licensure survey was conducted at your agency on January 19, 2011 through January 20, 2011, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of seven (7) active clinical records and one (1) discharge clinical record based on a census of eighteen (18) patients, seven (7) personnel files based on a census of ten(10) employees, and three (3) home visits. The deficiencies cited during this survey were based on interviews conducted with agency staff and review of clinical and administrative records and observations. | | | H 000 | Department of Health Health Regulation & Licensing Admi Intermediate Care Facilities D 899 North Capitol St., N. Washington, D.C. 2000 | ivision E. | |
| H 144 | personnel records following informati (d) Documentation | igency shall maintain : , which shall include t | ha | - | What corrective action(s) will be accomplished to address the identification practice; | ed |
| | Based on staff into Home Care Agent current Cardio Pul cartification was o | t met as evidenced by erview and record revi by (HCA) failed to ensi imonary Resuscitation ompleted and records of each staff as requin | ew, the ure that a (CPR) Id in the | | CPR certification is required on all clir participating in direct patient care. Di provided proof of certification upon i ongoing as re-certification becomes of the measures will be put into place systemic changes you will make to a that the deficient practice does not into the deficient practice does not doe | rector is hire and due. 2/8/2011. |
| . ! | | t's personnel record (p.m. revealed there w on file. | reas inc | ر والم | Director will keep a competency trace with all licensure and certifications expressions. Continued on next particles and continued on next particles. | ntered in ling 2/8/2011 |

LABORATORY DIRECTOR'S OR PROMOER/SUPPLIER REPRESENTATIVE'S SIGNATURE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A BUILDING 8, WING | | (X3) DATE SURVEY COMPLETED | | | |
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| | | | | 01/20/2011 | | | |
| HCA-0032 | | | 71.71 N. COOF | V 1/2 | W2011 | | |
| NAME OF PI | romder or supplier | | | | STATE, ZIP CODE AVENUE, NW, SOUTH BLDG SUIT | | |
| ALEREW | Men's and Chil | Dren's Health I | WASHING | TON, DC 2 | 0004 | | |
| (XA) O SUMMARY STATEMENT OF DEPICIENCES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | | IO PREFIX TAG | PROVIDERS PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPL DEFICIENCY) | ULD 8E | COMPLETE DATE | |
| H 148 | | | | H 148 | How the corrective action(s) will be monitored to ensure the deficient will not recur, i.e., what quality ass program will be implemented; Competency tracking log will be revited beginning of each month in orderable to notify employees of impendiexpirations. The CPR card for this envas produced before the end of the See exhibit 1 Please see the next page for on Personnel Section 3907.2 | practice urance sewed at or to be onployee survey. | 2/8/2011 |
| | Care Director (HCD confirmed a copy of verification was not the Director and the | acility's Director and b) on the same day a f the pre-employmen on file for these stall HCD agreed to fax rification to this surve | t 4:35p t f. Both a copy of | | | | |

| Health Re | equiation Administr | /ation | | | | ALAL CATE PIL | , |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | | T STREET AD | CRESS, CITY, ! | STATE, ZIP CODE | | 1 |
| • | ROVIDER OR SUPPLIER | | 661 PENN | NEYLVANIA / | AVENUE, NW, SOUTH BLDG SU | ate | |
| ALERE W | YOMEN'S AND CHIL | Loren's Health | WASHING | STON, DC 20 | 0004 | | |
| (X4) ID PREFIX TAG | JEANN DEEP IEM | TATEMENT OF DEFICIENCIA ICY MUST BE PRECEDED BY R LSC IDENTIFYING INFORM | Y FUILL | PREFIX TAG | PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | COMPLETE DATE |
| H 150 | H 150 Continued From page 2 before the close of survey on 1/20/2011. | | 1. | H 150 | What corrective action(s) will be to address the identified deficie | | |
| | The facility failed to ensure accurate documentation of all staff's previous employment as required by this section. | | | U = 59 | previous employment are compl employees. Historically a summa | Criminal background checks and verification of previous employment are completed on all new employees. Historically a summary of results was provided to the DC site with the original | |
| H 153 | Each home care a | agency shall maintain | n accurate | H 153 | results maintained at the corpora Moving forward, copies of comp be placed in all personnel record | ate office. plete results will | 2/2/2011 |
| | personnel records, which shall include the following information: (i) Documentation of any required criminal background check; This Statute is not met as evidenced by: Based on staff interview and record review, the Home Care Agency (HCA) failed to ensure that the criminal background screening for all staff was completed and recorded in the personnel record of each staff as required by this section. The finding includes: Review of Staff #1 's personnel record on | | | | What measures will be put into | niace or what | 2/8/2011 |
| , | | | | | systemic changes you will make the deficient practice does not r | to ensure that | |
| | | | | | Results of the Criminal Backgroun verification of previous employm placed in the personel record in I being maintained at the corporat | nent will be DC rather than | |
| | | | | | How the corrective action(s) will to ensure the deficient practice | | 2/8/2011 |
| | | | | | i.e., what quality assurance prog | | |
| ; | 1/19/2011 at appr | roximately 3:10 p.m. n ninal background chac | revealed | | The Director will obtain a copy of Background Check and verification | | |
| | care Director (HC confirmed a copy screening was no Director and the Hthese screenings Battimore, Marylai a copy of the back to the survey team | e facility 's Director and CD) on the same day or of the criminal backgot on file for this staff. HCD indicated the restant the main of and. The Director agrickground screening for the close of the cl | at 4:38p ground Soft the suits of office in reed to fax or this staff | | employment completed on all ne Copies of the complete reports w maintained in the employee file is requirement has been added to to completed for each new employed will be monitored by checking 10 personnel records quarterly. The checks were produced to the survey. | ew employees. vill be in DC. This the checklist ee. Compliance 70% of requested | |
| | 1/20/2011. | | | | | | 2/8/2011 |

Health Regulation Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPL/ER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 01/20/2011 HCA-0032 STREET ADDRESS, CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 501 PENNSYLVANIA AVENUE, NW, SOUTH BLDG SUITE ALERE WOMEN'S AND CHILDREN'S HEALTH! WASHINGTON, DC 20004 PROVIDER'S PLAN OF CORRECTION (XII) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) IC PREFIX EACH CORRECTIVE ACTION SHOULD BE (X4) IO DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY) TAG H 153 H 153 Continued From page 3 : The facility failed to ensure the criminal background checks for all staff were completed and recorded as required by this section. H 366 H 366 3914.4 PATIENT PLAN OF CARE What corrective action(s) will be accomplished to address the identified Each plan of care shall be approved and signed by a physician within thirty (30) days of the start deficient practice; of care; provided, however, that a plan of care for Alere will request the referring physician to personal care aide services only may be approved and signed by an advanced practice 2/8/2011 sign the POC at the time of referral. registered nurse. If a plan of care is initiated or What measures will be put into place or revised by a telephone order, the telephone order what systemic changes you will make to shall be immediately reduced to writing, and it ensure that the deficient practice does not shall be signed by the physician within (hirty (30) recur: days. At the time of referral, the referral source will be informed that Alere will fax the POC for This Statute is not met as evidenced by: Based on record review and interview, it was signature. In instances where the referring determined that the agency failed to ensure the physician is not able to sign the POC at the Plan of Care (POC) for one (1) of eight(8) time of the referral, every attempt will be patients was approved and signed by a physician made to obtain the signature within 20 days within thirty (30) days of the start of care. (Patient of the referral. All orders not signed within 20 #7) days will be hand delivered to the physician by Alere staff. 2/8/2011 : The finding includes: How the corrective action(s) will be On January 19, 2010, a record review of patient monitored to ensure the deficient practical #7's record at approximately 12:28 p.m. revealed will not recur, i.e., what quality assurance a POC with certification period of December 10, 2010 through June 21, 2010 in which the program will be implemented; physician ordered Nursing Visit and PRN We have implemented a quality Supervision: Instruct patient per protocol on DMS improvement initiative whereby all orders 200, Self Blood Glucose and Ketone Monitoring. will be tracked to insure signature within 30 and Nutrition Requirements. days of receipt of order. 2/8/2011 There was no documented evidence of a physician approval or signature within thirty

Health Regulation Administration STATE FORM

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| Health R | egulation Administra | ation | | | | | |
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| | HCA-0032 | | 8. WING | | 01/2 | /20/2011 | |
| NAME OF P | ROYDER OR SUPPLIER | (1004-0104 | STREET AD | DRESS, CITY, ! | STATE, ZIP CODE | *** | |
| 801 PENN | | | NSYLVANIA AVENUE, NW, SOUTH BLDG SUITE 9TON, DC 20004 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF ([EACH CORRECTIVE ACT! CROSS-REFERENCED TO TI DEFICIENCE | ON SHOULD BE HE APPROPRIATE | COMPLETE DATE |
| H 386 | Continued From pe | ige 4 | | H 366 | | | |
| | (30)days of the sta | rt of care. | | | | | į |
| | During a face to face interview with the District of Columbia Home Care Director and the Clinical Director for Baltimore on January 19, 2010 at approximately 4:05 p.m., the finding was acknowledged. | | | | | | |
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